

Family Medical Clinic of North Mississippi, Inc.
REGISTRATION FORM

(Please Print)

Today's Date:				Email:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle :	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):			Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance:		Address:			Phone: ()		
Cardholder employer:		Address:			Phone: ()		
Subscriber's name:		Subscriber's SSN:	Birth date:	Policy No.:		Group No.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Subscriber's DOB:	Policy No.:	Group No.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()	Work phone no.: ()	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic/physician. I understand that I am financially responsible for any balance. I also authorize Family Medical Clinic of North Mississippi, Inc or insurance company to release any information required to process my claims. I accept full responsibility for any reasonable attorney's fees, court costs and legal fees associated with the collection of this account if there is a default in payment. I understand that Family Medical Clinic of North Mississippi, Inc utilizes family billing; therefore the charges associated with any visit may be viewed by other family members. I have been offered a copy of Family Medical Clinic of North Mississippi's Notice of Privacy Practices.</p>							
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>			

RELEASE OF MEDICAL INFORMATION BY ALTERNATIVE MEANS

Patient Name:		SSN:	DOB:
Dependent Children:	DOB:	SSN:	Additional:
1)Name			
2)Name:	DOB:	SSN:	Additional:
3)Name:	DOB:	SSN:	Additional:
4)Name:	DOB:	SSN:	Additional:

I authorize Family Medical Clinic of North Mississippi, Inc to release the following medical information as listed below:

Return Appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No		X-Ray Results: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Out Patient Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No		Return Calls: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Lab Appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Family Medical Clinic of North Mississippi, Inc can release the above information to the following people: (Parental/Legal Guardian release is implied unless noted, court order is required)

Name:	DOB:	Relation:	Notes:
Name:	DOB:	Relation:	Notes:
Name:	DOB:	Relation:	Notes:
Name:	DOB:	Relation:	Notes:

Family Medical Clinic of North Mississippi, Inc. can release the above information by the following means: (enter phone number or address)

Answering Machine:		Voice Mail:
Mobile Phone:		E-Mail Address:
Fax:		Other:

Signature of the release Revokes any previously signed release on file. We reserve the right in accordance with our Notice of Privacy Practices to release information if we feel there is a serious threat to the health or safety of a patient.

Patient/Guardian signature

Date

CONSENT TO TREAT

I (or my legal guardian/parent) authorize Family Medical Clinic of North Mississippi, Inc. to provide medical care reasonable to today's standards

Patient/Guardian signature

Date